Middle Georgia ORTHOPAEDICS
Specializing in You

Warner Robins
3051 Watson Boulevard, Suite 525
Warner Robins, GA 31093

Perry
1013 Main Street
Perry, GA 31069

Hawkinsville
42 Truman Road
Hawkinsville, GA 31036

www.MGO.md | Phone: (478) 953-4563 or (478) 953-4611 | Fax: (478) 953-4564

Patient Information

Full Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Birth Date: _____/_____/_____ Patient SSN: _____ Marital Status: _____

Parent of Guardian (Complete if Minor): _____

Birth Date: _____/_____/_____ SSN: _____ Primary Care Doctor: _____

Skilled Nursing Facility Address: _____

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other _____

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Pacific Islander
- ☐ White
- ☐ Other _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Contact:
- ☐ Mail
- ☐ Phone
- ☐ Email
- ☐ Text

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____ Employer: _____

Pharmacy: _____ Pharmacy Location: _____

Insurance Information

Primary Medical Insurance: _____

Insured Party:
- ☐ Self
- ☐ Spouse
- ☐ Parent

Policy Holder Name: _____

ID Number: _____ Group Number: _____

Policy Holder's Birth Date: _____/_____/_____ Policy Holder's SSN: _____

Secondary Medical Insurance: _____

Insured Party:
- ☐ Self
- ☐ Spouse
- ☐ Parent

Policy Holder Name: _____

ID Number: _____ Group Number: _____

Policy Holder's Birth Date: _____/_____/_____ Policy Holder's SSN: _____

Information Disclosure to Family Members (Optional)

I authorize Middle Georgia Orthopaedics to disclose information regarding my medical treatment and health coverage to the following individuals:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Signature: _____ Date: _____

PLEASE READ AND SIGN THE BACK

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Release of Information

I authorize Middle Georgia Orthopaedics to receive and disclose any non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Notice of Privacy Practices Patient Acknowledgement

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information. I have received, read, and understood the notice of privacy practices. I also understand Middle Georgia Orthopaedics reserves the right to change the terms of its notice of privacy practices at anytime and will provide a current notice of privacy on request.

Assignment of Benefits

I hereby assign Middle Georgia Orthopaedics any insurance or other third party benefits available for health care services provided to me. I understand that Middle Georgia Orthopaedics has the right to refuse or accept assignment of such benefits. I agree to forward to Middle Georgia Orthopaedics all health insurance and other third party payments that I receive for services rendered to me immediately upon request.

Consent for Treatment

I authorize Middle Georgia Orthopaedics and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, indicated.

Financial Policy

I understand that Middle Georgia Orthopaedics has instituted a standard financial policy regarding payment for services rendered at their facilities or in hospital setting by members of the practices. I have received, read, and understood the practice's financial policy and I agree to the terms of the policy. I also understood and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient.

Signature: _____

Printed Name: _____ Date: _____

Middle Georgia Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.